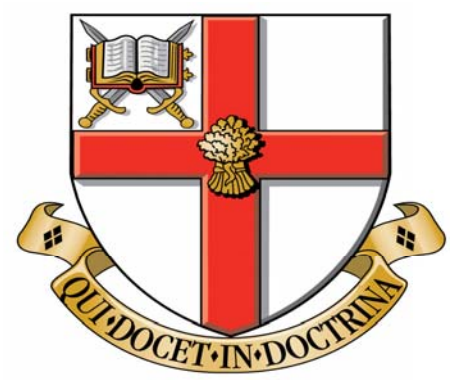

The Role of Midwives With Reference to Preparation for Parenthood : A Case Study

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Abstract

This dissertation is predominately a review of literature regarding the midwives' role in preparation for parenthood. The literature is reviewed to assess the evolution, purpose and aims and effectiveness of antenatal education. Fundamental issues regarding how education in general can serve to oppress or liberate are examined along with the purpose and aims specific to antenatal education. The study concludes that there are many differing aims of antenatal education, often causing a lack of clarity for the midwives who deliver this education.

The dissertation examines studies on measures, benefits and effectiveness and finds that the results of these studies are often inconclusive and sometimes contradictory.

A small scale primary study using postal questionnaires informs the dissertation. Questionnaires were sent to all mothers who delivered during a two week period three months and six months prior to receiving the questionnaire. Questionnaires were also given to all practising midwives working in the same area. The questionnaires aimed to identify whether clients' expressed needs were matched with midwives' perceptions of client needs. An analysis of the results shows that both midwives and clients agree that the subjects of labour and delivery and pain relief during labour are the most important subjects to discuss during antenatal education.In this study both clients and midwives prefer antenatal education to be delivered on a one-to-one basis. Midwives recognise a need for increased education for themselves to develop their teaching skills with regular updates. It was found that most midwives considered that their training was not sufficient for this role. The dissertation recommends that antenatal education should serve to liberate parents and empower women, enabling them to take control and make informed choice during the process of childbirth. It advocates that midwives should be supported and helped to take on this role. The need to explore alternative methods of delivering antenatal education is identified.

Declaration

The work is original and has not been submitted previously in support of any degree qualification or course.

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INTRODUCTION.

The role of the midwife with reference to preparation for parenthood : a case study

This dissertation examines the role of midwives with reference to preparation for parenthood. Wherever possible only primary sources have been drawn on. The dissertation mainly involves using information derived from a literature review, but also includes a small scale study in which mothers' and midwives' views about various aspects of preparation for parenthood are examined. Midwives have different roles to carry out such as providing antenatal care, care during labour and childbirth and postnatal care. Preparing prospective parents for parenthood is often assumed to be an integral part of the midwife's role, both by clients and the midwives themselves. Article 4 of the European Community Midwives Directive 80/155/EEC which defines the activities of a midwife states that a midwife's activities include providing

> a programme of parenthood preparation and a complete preparation for childbirth, including advice on hygiene and nutrition.

In 1902 the Midwives Act (England) set up the Central Midwives Board to register practising midwives. The Board produced a recognised syllabus for the training of midwives, but this did not become compulsory until 1936. This was a practical training with no opportunity for teaching mothers in the antenatal period. In the 1940's, training for midwives was firmly established and consisted of two parts. Part I (after State Registration as a trained nurse) consisted of six months training to work in a hospital as a maternity nurse. Part II, also lasting six months, led to qualification to work independently, mostly caring for women in their own homes (Williams & Booth 1984). Mothercraft classes were established throughout the country with the setting up of the National Health Service in 1948. During the 1970's Part I and Part II of the training for midwives were combined to form a one year training programme for qualification as a midwife following state registration as a trained nurse. Class

teaching was added to the syllabus , and each student had to participate in antenatal teaching (Williams & Booth 1984). In 1980 the Central Midwives Board changed the training of midwives to eighteen months for State Registered Nurses. Their basic syllabus stresses the important contribution midwives make to health education, particularly matters concerning child-bearing, childbirth and preparation for parenthood.

It is not clear how and why antenatal education has developed . In earlier times birth was a social event and parents were well acquainted with it through their extended families. Urban crowding and health problems attributed to the Industrial Revolution in the late 19th century affected change in societal attitudes towards childbirth (Lindell 1988) . Lindell (1988), in an article in which she reviews the history and literature of the development of childbirth education, identifies three influential factors which had a fundamental impact and influence on changing attitudes towards childbirth in North America, and which combined to move childbirth away from the control of women. These factors were :

1. The emergence of obstetrics as a male-dominated practice
2. Continued urbanisation and industrialisation which effected family roles,
3. The introduction of drugs and obstetric techniques to control pain and combat puerperal infection.

(p108)

These factors combined to take the childbirth experience away from the women in their own homes accompanied by midwives and family to the medical profession within the hospital domain. Childbirth was no longer a social event, but had become a medical event under the control of doctors who were predominantly male.

It would seem from reviewing the literature, that antenatal education in the UK has developed from two separate traditions. The first aimed to educate parents about nutrition and hygiene as part of the strategy to reduce perinatal and infant mortality.

The second focused on various methods to reduce pain in labour (Murphy-Black 1990). There are two basic assumptions made here. The first is that antenatal education can achieve these aims and thus reduce perinatal and infant mortality as well as pain in labour, and secondly that midwives are the best people to provide that education.

This dissertation examines these two assumptions in depth. Firstly, the stated aims of antenatal education and whether they are addressed are examined. This gives rise to other issues such as how the effectiveness of antenatal education can be measured. Many attempts have been made to measure the effectiveness of such education. Educationalists see evaluation in terms of the effects on maternal and infant mortality and morbidity (Greenberg and Sullivan 1977). Maternal and infant mortality and morbidity have fallen during this century but it may not necessarily be due to education. Other schools of thought believe that the benefits of antenatal education are the positive feelings about childbirth which it engenders. (Genest 1981). Investigations into the benefits and effectiveness of antenatal education have produced conflicting results. Some studies have reported significant reductions in the amount of analgesia used and a significant increase in the number of spontaneous normal deliveries in mothers who attended parentcraft classes compared to a group which did not (Hetherington 1990). Whereas Gunn et al (1983) found no significant difference in terms of analgesia required during labour between mothers who attended parentcraft classes and those who did not. Husband (1983) concluded that antenatal classes can improve women's level of knowledge as did a study by Redman et al (1991). What is not clear in these studies is whether the reported increase in knowledge was directly attributable to antenatal classes or was obtained in some other way and also what effects increased knowledge has on childbirth and childcare. Lumley and Brown (1993) reported that their study showed no significant difference in birth outcome, emotional well being or satisfaction with care between attenders and non-attenders at antenatal classes. While poorer obstetric outcomes by attenders at antenatal classes

were reported by Gunn et al (1983) and Sturrock and Johnson (1990). These conflicting results raise questions about the nature of the studies and also highlight the fact that there seems to be differing aims and evaluations for the classes as different outcomes are often measured. Many studies relate antenatal education to imparting information (Nolan 1994, Enkin 1990, Fleissig 1993, Mackay and Yager Smith 1993) but there is evidence to suggest that giving information is not enough. Plant (1991) believes that most health education is aimed at literate white people in socio-economic groups II and III and that it is still uncommon to see health education that takes people's lifestyles, differing levels of education, background and religious beliefs into account. Unhealthy behaviours can be caused by many different factors which health education alone may find difficult to counter.

The second assumption that midwives are able to provide effective antenatal education is also examined. Pre- registration training and post- registration training are looked at to see how much emphasis is actually put on 'educating the educators'.
Often it is assumed that by virtue of the fact that midwives are midwives, they are able to deliver effective antenatal education. Ashton (1977), Brammer (1977), Sayle (1979) and Sweet (1984) have all highlighted the lack of preparation of midwives for this role.

Murphy-Black (1990), who has completed several studies on antenatal education and is referred to as an authority in many midwifery books and literature, makes several assumptions regarding the ability of midwives as teachers. These assumptions about the roles and capabilities of midwives seem to be based on the fact that they are midwives. The assumptions are that midwives by virtue of their training are already aware of :

- how to teach
- a basic knowledge of communication skills
- which skills are required in the management of group dynamics

- different approaches to health promotion
- the fact that antenatal education has to meet the needs of the parents to be of benefit. (Murphy-Black 1990 p88 & 89).

I am a midwife and have been involved in antenatal classes and education on a one-to-one basis with clients. I am also completing a Certificate in Education (Further, Higher and Adult Education), and have looked at theories of learning and teaching, which have made me realise how little I personally was prepared for the role of educator which the Midwife's Code of Practice (UKCC 1994) stipulates. Alongside this I also began to question the fundamental assumptions that as a midwife I was the best person to deliver antenatal education and that it was of any benefit in its present format. This has led me to look at the issues of preparation for parenthood further, and also in my own study to examine the opinions of a small sample of midwives with regard to this preparation.

The first chapter looks at how midwives have evolved as providers of antenatal education in a historical context as opposed to other health professionals or any other individuals. It also examines the relationship between clients and midwives in an educative context. The second chapter looks at the purpose of antenatal education. It examines the theories of education and Freire's (1972) view that education is never neutral, it either oppresses or liberates and applies these theories to antenatal education. This chapter also examines the aims in relation to preparation for parenthood specifically and from where they are derived, and questions whether they are attempting to meet the expressed needs of the parents or are rather derived from the perceptions of midwives of the needs of parents.

Many attempts have been made to evaluate the effectiveness of antenatal education. To measure effectiveness it is first of all necessary to identify aims, and as the first chapter shows, the aims of antenatal education are often diverse and still require clarification. Effectiveness is therefore measured in many different ways with often

conflicting results. Chapter three reviews the literature to date concerning the evaluation of the effectiveness of antenatal education. Chapter four examines the role of midwives as educators and also the emphasis placed on midwifery training today with regard to educating the educators. Within this chapter are accounts of interviews with three student midwives who were working at the hospital where the study took place. The interviews were semi - structured as I asked them to talk about their views on their preparation as educators. Although these interviews cannot be representative they can be used to illustrate the findings from the literature review. Chapter five is an account of my own small scale study, which involves using questionnaires to try to ascertain both midwives' and parents' opinions about antenatal education provision. It examines and compares the differences between midwives' and parents' perceptions about what is most important with regard to preparation for parenthood. Midwives' feelings regarding their preparation to deliver antenatal education are also examined. The chapter includes the methodology of the study , and presentation and analysis of the findings.

The conclusion draws together the findings of the literature review and my own study. Findings are discussed and suggestions for further studies, as well as possible changes within midwifery and midwifery education are suggested.

CHAPTER ONE

Education for Parenthood - The evolving relationship between client and midwife

This chapter examines how and why midwives evolved as providers of antenatal education and preparation for parenthood and the relationship which exists between client and midwife. As previously stated, 'Mothercraft classes' were established countrywide with the setting up of the National Health Service in 1948 although class teaching was not introduced to the midwifery training syllabus until the 1970's during which time the 'parentcraft sister' emerged (Williams and Booth 1984, Nunnerley and Deane-Gray 1988). As pointed out by Rees (1993) the provision of antenatal classes has now become an accepted part of the midwifery service and these classes are now often taken for granted, both by midwives and by the clients. Midwife means 'with woman', and in 1927 when live births were tabulated by place of birth 85 per cent of births took place at home with a midwife in attendance. In the 1960's and 1970's there was a shift from home to hospital deliveries and alongside this there came an increase in the role played by the medical profession in childbirth. In 1970 a report by the Standing Maternity and Midwifery Advisory Committee (Chairman J. Peel) was published which proposed that the maternity service should no longer offer the option of home delivery. Ashton (1992) believes that during this time women and obstetricians were united with women demanding a safe birth and a perfect baby and obstetricians advising that this was more likely in a hospital setting. During this period of time there was also a rapid development in technology and increasing interventions into the birth process. All these issues helped to take control away from women and female dominated midwifery and firmly establish childbirth within a medical model. Obstetrics is a predominantly male dominated profession based around science, intervention and the abnormal. Midwifery is historically a profession struggling to

maintain its independence within a patriarchal medical hierarchy. With increasing medical interventions there perhaps inevitably came two fundamental outcomes :

i By intervening in the childbirth process, obstetricians took on a more powerful role in childbirth thus increasing their control over women, due, some believe, to the male medical profession's expansionist tendencies (Oakley 1979).

ii Midwives lost their independence in the childbirth process and found themselves increasingly under medical patriarchal control.

These two outcomes possibly increased the need for antenatal and parenthood education, as the process became more medicalised and less 'natural' and was taking place in a strange environment rather than predominantly in the home environment as previously.

Women have been placed at the centre of care by the Health Select Committee Report (DoH 1993) into maternity services which says that women's needs and wishes are paramount. Midwives have been encouraged to examine their practices to ensure that women are enabled to make choices about their care during the childbirth process and enabled to do this by being informed and educated about choices. However, within the midwife - client relationship midwives may not wish to relinquish control over the women they care for. There are many aspects of habitualised care within the midwifery profession which may not promote client control over their own experiences. One example highlighted by Thomas (1995) is that of the 'Baby Bath Demonstration' which is one of the main postnatal areas covered in parentcraft classes. Thomas (1995) gives an account of a baby bath demonstration and concludes that the fact that women need to be 'taught' by a midwife how to care for the basic needs of their own babies emphasises the power and control that midwives have over their clients, often through the ritualistic practices that permeate midwifery care.

The British Paediatric Society was founded in 1928, and doctors specialising in the care of ill children came to consider themselves expert in all aspects of childcare

generally (Oakley 1986). They considered that women, especially working class women, were ignorant in babycare and needed educating. Professionals, midwives included, offer advice on the 'right' way to feed, hold and bath babies, and check and confirm the baby's development as 'satisfactory', thus reducing women's intuitive knowledge and judging the accumulated wisdom of the social group as inexpert. Professionals' advice is then regarded as valid and authentic (Miles 1991). Not only has medicalization of childbirth taken place within the public domain of the hospital environment, but it has also impinged on the domestic domain. Midwives (and other health workers) are available with opinions and advice, backed up with scientific evidence and designed to promote 'good health' within the home and in relation to parenthood and marriage. There are many subtle relationships which occur between midwives and the women they care for which again are to do with power and control. The literature assumes that midwives will be happy to give control and choice over to women. Nothing has been found in the literature which questions this assumption and queries whether or not midwives enjoy the control and power they have over pregnant women. Implicit within the power relationship is the knowledge that the midwife has and is willing to impart to her clients by way of antenatal education. An example of this way of thinking is in an article written by Ruth Ashton (1992) who was at the time General Secretary of the Royal College of Midwives. In it she says that midwives cannot be womens' advocates because their knowledge, skills and professional status set them apart from women in general. However Miles (1991) expresses the view, based on research by Blaxter and Patterson (1982) and Cornwell (1984), that women believe that midwives are not able to provide professional, expert opinion, rather they are able to offer common sense lay advice and that knowledge derived from personal experience is valued over book learning. She goes on to say that antenatal classes are mostly attended by first-time mothers and those with experience with second-time and subsequent babies feel much less need for those services. This was also found to be the case in the small scale study which is detailed in Chapter five.

The power position of patients vis-à-vis midwives is a complex one, one which it is wrong to assume that midwives would want to relinquish, and by being the providers of antenatal education in its present form this power position could potentially be perpetuated. Freire (1972) said that education is never neutral, it either oppresses or liberates. This could be applied to antenatal education - it can either oppress or liberate, depending on its aims and objectives. Chapter two examines in depth the aims and objectives of antenatal education and assesses the extent of the oppression or liberation this may bring about.

CHAPTER TWO

The Purpose of Antenatal Education.

Two issues are examined in this chapter. Firstly antenatal education is examined in terms of whether it oppresses or liberates parents. Secondly, the question of whether the antenatal education needs of parents are being met by midwives is examined. In order to address these two issues it is necessary to examine the purpose of antenatal education. It is only possible to meet needs adequately if those needs are identified and then addressed. Most antenatal education programmes claim to be based on the learning needs of pregnant women, but within the literature reviewed there has been little evidence that this is so.

From reviewing the literature there appears to be a basic lack of clarity about the purpose of antenatal education. Often midwives will say that one of the purposes of antenatal classes is to 'prepare women for delivery' (Rees 1993). Nunnerley and Deane Gray (1988) state that

> The aim of parent education is to prepare parents for the task of producing and caring for their children.
> (p66)

'Prepare' can imply that the parents are the passive recipients and midwives are the active participants in childbirth preparation, and can cover a wide range of approaches and subjects. Rees (1993) points out that midwives rarely stop to ask themselves the question 'what are antenatal classes for?' , yet they continue with the traditional 'talk and exercise' routine. If the purpose of antenatal classes is not clearly defined, it is difficult for midwives as educators to provide a service that meets the needs of parents.

Freire (1972) talks about the 'banking' concept of education, whereby knowledge is considered to be a gift bestowed by the knowledgeable to the unknowledgable. He identifies ways in which the banking concept of education mirrors oppression within society, such as :

> The teacher teaches and the students are taught
>
> The teacher knows everything and the student knows nothing
>
> The teacher chooses and enforces his choice and the student complies
>
> The teacher talks and the students listen
>
> (p46-47)

In contrast to the banking concept of education he identifies liberating education whereby students and teachers become jointly responsible for the process of teaching and learning, and consequently teach each other. In liberating education Freire (1972) believes that teachers present material to students for their consideration. Students are not docile listeners, they are working in partnership with their teacher in an investigatory capacity. Empowerment of women, and offering them more choice and control implies a liberating approach to antenatal education. This approach has practical implications for midwives in their educative role. It suggests that the didactic method of passing information to a listening audience only serves to oppress that audience and that in order for midwives to empower women, to liberate them and to offer control to them, antenatal education needs to be approached in a liberating way. The liberal perspective of education as identified by Haralambos and Holborn (1995) has similar ideas. It focuses on the individual and its viewpoint is that education should promote the well-being of the individual and help to develop their personal development and fulfilment. Haralambos and Holborn (1995) say that liberalists feel that liberal education is vital for democracy where power rests with the people. For people to exercise their power, they need to be able to think for themselves. Again this philosophy agrees with the concept of empowering women, thus enabling them to

make their own choices and thus take control of their lives. Part of this empowerment must lie with education which is liberating.

In order for midwives to be effective educators, as well as the fundamental issue of whether that education serves to oppress or liberate, the needs of parents in terms of subjects to be addressed also requires identification. Ford (1994) identifies several areas of concern with the present provision of antenatal education. These include the concerns that needs and provisions are mismatched, and aims are unclear. This is examined further in the small study documented in chapter five. Clients and midwives were asked to identify and rank subjects they felt to be important. The results were then compared to see if, within this small study , needs and provision may be mismatched. Antenatal education needs to have a clear purpose and aims that are meeting the needs of parents. Educators can then attempt to achieve those aims and meet the needs.

Hancock (1994) cites several aims of antenatal education which are examined in more depth in this chapter. These aims were identified by midwives and childbirth educators in a large piece of research which was done on behalf of the Health Education Authority in Coventry (Combes and Schonveld 1992) and are ;

1. Influencing health in pregnancy
2. Making labour easier
3. Teaching parenting skills
4. Increasing parents' confidence
5. Developing support networks

The first two are similar to the two separate traditions identified by Murphy-Black (1990) from which antenatal education developed, i.e. education about nutrition and hygiene in an attempt to reduce perinatal and infant mortality and to reduce pain during labour and childbirth.

Influencing Health in Pregnancy.

Antenatal education tends to be more prominent in the latter stages of pregnancy possibly because women who work have commenced maternity leave. Antenatal clinic attendances also become more frequent, therefore increasing contact with the midwives. Formal antenatal classes usually commence during the last trimester of pregnancy. For these reasons it is difficult to reconcile this with the ability to influence health during pregnancy. Most potential damage to the fetus caused by unhealthy behaviour takes place in the first trimester whilst fetal development is at its greatest, often before the woman is aware she has conceived. Advice about lifestyle and diet later on in pregnancy may be too late. Some advocates may argue, however, that lifestyle may be changed before any subsequent pregnancy.

Even if antenatal education were available much earlier in pregnancy, or even pre-conceptually, it may be unrealistic to believe that education by the midwife could bring about a change in lifestyle that is part of the individual's culture. To women living in poor housing or abject poverty antenatal education may have little relevance (Hancock 1994). Unhealthy behaviour is part of a much wider arena which includes social, societal, environmental and political issues. These issues need to be addressed at all levels as healthy or unhealthy lifestyle is concerned with more than an individual's choice. O'Connor (1993) points out that opinions and ideas are starting to form in childhood, and by adulthood, habits and ideas are already formed. There is little evidence to suggest that antenatal education has played any part whatsoever in the reduction in perinatal and infant mortality. Midwives may need to become aware of these factors and perhaps recognise that possibly antenatal education may have other roles than those of influencing health behaviours in women.

Making Labour Easier.

Dr. Dick-Read was a British obstetrician who published a book entitled 'Childbirth Without Fear' in 1944. Women started to question the need for such rigid medical intervention during the 1950's and 1960's and there was a movement toward more natural childbirth. Dr. Dick-Read's book was based on the idea that pain during labour can be reduced or eliminated by reducing the amount of fear, apprehension and tension which is associated with labour (Lindell 1988). His ideas have had a great influence on this aspect of antenatal education. He believed that birth is a normal physiological function and should not give rise to pain, and that culture and civilisation introduced fears and anxieties about childbirth, causing tension throughout the body which then leads to pain (Williams and Booth 1984). Dr. Dick-Read believed that information about childbirth helped to resolve those fears and anxieties, and he also advocated deep breathing and relaxation as a method of pain control. This appealed to a growing movement of exponents for more natural childbirth and midwives began to adopt his ideas. The book became a classic on which many pain control techniques today are based. He was followed by Ferdinand Lamaze who prescribed carefully structured breathing and relaxation programmes. Most pain control techniques used today are modifications of the ideas of both Dick-Read and Lamaze (Lindell 1988). However, women's needs vary. Their perceptions of pain are different, they react in different ways to pain and anxiety and they have different ways of coping. Typical antenatal education offers a set prescription for success in childbirth which often does not take these differences into account (Lindell 1988). Swinnerton (1990) argues that labour only lasts 24 hours at most and more emphasis should be put on preparation for parenthood rather than pain relief in labour. As Kitzinger (1993) says, childbirth is;

> A psycho-physical journey as a new life enters the world, and the often stressful transition to parenthood that extends well into the first year after.
>
> (p. 216)

This statement also emphasises that childbirth is not only about the actual physical aspect of labour and birth. Chalmers and McIntyre (1994) also say that antenatal classes have traditionally been designed to prepare mothers for childbirth but childbirth is a short lived, though important, event. They say that more emphasis should be placed on the need to prepare mothers and families for parenthood. These two opinions both put forward the view that antenatal education should be preparation for parenthood as opposed to preparation for childbirth which most of the emphasis of making labour easier and controlling pain is based on. Daub (1992) argues that the knowledge of how to give birth is stored in the primitive part of the brain of every women. Any attempt to stimulate the cognitive part of the brain will interfere with the ability of the primitive brain to give birth instinctively. If midwives feel that they have to 'teach' women how to give birth then they, in effect, may be taking away that primitive instinct. Midwives could, in fact, be interfering with the natural process in their attempts to educate about childbirth. Another factor to consider is previous experiences of pain during labour over which the midwife caring for the woman during the present labour has no control. These studies all appear to say that education for childbirth has limited benefits and that the emphasis for education should perhaps lie elsewhere.

Teaching Parenting Skills.

Teaching parenting skills opens up the nature-nurture debate. Is there really a need to teach these skills or are they innate within all parents? Nolan (1994) says that mothers and fathers have an innate capacity to rear their own children. If this is true this implies that there is no need to attempt to teach these skills. If, however, these skills need to be nurtured and there is some requirement to learn these skills are midwives the most influential people to help that learning need? For example, most women have already decided how they wish to feed their baby before they come into contact with their midwife. Parenting lasts for many years and midwives have a statutory

requirement to care for women up to the tenth postnatal day, for a maximum of twenty eight days. It may be that there is a limit to how much responsibility or influence a midwife has in teaching parenting skills and that there are more appropriate people available, if indeed there is actually a need for this learning.

Nolan (1994) asked parents attending a postnatal group to write down what had most worried them during the first few weeks of parenthood. Nobody cited the practicalities of baby care. Bathing, feeding and changing procedures are quickly learnt within the first few days of a baby's birth and family and friends play a much larger role in influencing parents. This study highlights the issue of whether it is or should be the midwife's role to teach parenting skills and indeed whether there is a need for parents to be taught parenting skills in a structured way at all. By means of anticipatory socialisation most people are exposed to parenting skills in one way or another through the media and through family and friends.

In a study by Hibbard (1989) it was found that the main source of information for women with no children was television, occupying a mean total of 75 hours a month. Reading did not have a high priority. Yet much of professionally offered antenatal education has centred around the provision of reading material and organised classes (Hibbard 1989). It could be that the power of the media is not recognised sufficiently by professionals who are involved with antenatal education and that possibly more advantage may be taken of this power.

Increasing Parents Confidence.

Antenatal education is an opportunity to introduce parents to options and choices about childbirth. In this way it has the ability, though still at the mercy of their own and health service limitations, to empower women (Rees 1993). Hancock (1994) argues that when parents are informed to an extent that they can make choices and

decisions, they can become active participants rather than passive recipients of midwifery care. She does not address the issue of how they are informed however, which is also important. As Freire (1972) suggested, education itself should involve active participation from students (in this case parents) in order for it to liberate. Confidence is very difficult to measure. Parents' levels of confidence may differ prior to any antenatal education from midwives, and it is very hard to provide evidence that antenatal education has an impact on parents' confidence about their abilities to cope with childbirth and parenthood. Hillier and Slade (1989) conducted a study of 67 primipara attending antenatal classes. They asked the subjects to assess their own levels of confidence prior to the first attendance and when the course was completed. Subjects were asked to rate their confidence in their ability to cope in labour and their confidence in looking after a new baby. They found a substantial increase in the level of confidence reported over the period of the classes. The study did not follow through so it was not clear what, if any, effects the increased knowledge and confidence had on other factors such as birth outcome, perinatal and infant mortality, parenting skills etc. This study was limited to subjects who attended antenatal classes so was not able to examine confidence levels of women who didn't attend structured classes which could introduce an element of bias into the results. There is no way of knowing whether confidence increases due to other factors such as family and friends' support or education from other sources. Further studies need to be conducted to assess further the impact that antenatal classes have on womens' confidence levels and indeed whether this should be an aim of antenatal education.

Developing Support Networks.

Rees (1994) identifies one feasible aim of antenatal education classes as the provision of opportunity for people in similar situations to come together and obtain answers to questions in a supportive environment. Western family structure has, over recent

decades, moved from the extended to the nuclear structure. So support and advice from extended family members is not readily available. Of course, antenatal education which takes place individually will not create the opportunity to develop support networks. It may be that an opportunity to meet with other people in a similar situation could be organised without the need for 'educational input'. It is not necessarily the antenatal education itself which helps to provide the support network, but the opportunity which arises from antenatal classes for people to come together.

The review of literature has identified that there are several differing aims of antenatal education which are often based on assumptions about the needs of parents. If midwives are making assumptions about the purpose and aims of antenatal education it is difficult to conclude that they are identifying and meeting the needs of parents. Whilst reviewing the literature it was noted that often there is little mention about the involvement of prospective fathers in antenatal education. Combes and Schonveld (1992) concluded that men still miss out, even though they are now increasingly involved in child care. Apart from references to choice and control advocated by Changing Childbirth (DoH 1993) no evidence was found in the literature reviewed which addressed the question of whether antenatal education oppresses or liberates, either explicitly or implicitly. As has been identified, there appear to be many differing aims of antenatal education. This makes it difficult to assess the benefits and effectiveness of this education. Chapter three looks at the attempts which have been made to measure such benefits and effectiveness.

CHAPTER THREE

Antenatal Education - How Beneficial and Effective is it?

For health professionals involved in antenatal education there is a presumption that antenatal education is of benefit (Butler 1985). However, the question of whether antenatal education is merely a ritualistic procedure passed down from midwife to midwife or a research based practice aimed at meeting the needs of parents needs to be addressed. Nolan (1994) says that the effectiveness of antenatal education has always been in doubt, despite consistent efforts over the last thirty years to determine its goals and evaluate its effectiveness. Yet antenatal education continues to develop in a seemingly haphazard way. Once again this highlights the issue of, if the purposes and benefits of antenatal education are uncertain, how it can claim with justification to meet the needs of parents?

As previously stated, Murphy-Black (1991) makes the assumption that midwives are aware that antenatal education has to meet the needs of the parents if it is to be of any benefit. Yet frequently research findings e.g. O'Meara (1993), Sturrock and Johnson (1990), Butler (1985) are unable to confirm its effectiveness and benefits, which shows flaws in Murphy-Blacks (1991) fundamental assumptions. If effectiveness and benefits continue to be questioned, one might begin to question these assumptions that midwives are aware of parents' needs and are addressing those needs. Many different approaches have been used in an attempt to determine the effectiveness of antenatal education. These different approaches may be due to the differing views on what the purpose of antenatal education is. O'Connor (1993) says that the effectiveness of antenatal education is frequently criticised, and she considers it reasonable, therefore, to question the value of it. She also questions why, if the same conclusions have been reached for the last 11 years , both from within and outside the profession, change is so slow in coming. This issue is now addressed through a review

of the literature which shows that attempts to measure benefits and effectiveness of education for parenthood tend to fall into three categories :

1. Physical outcomes of labour and childbirth.
2 Psychological and emotional outcomes.
3. Levels of knowledge and confidence.

It is not evident from the literature whose categories they are - providers or consumers. If they are not consumers' categories benefits and effectiveness are measured against providers' perceptions of the aims of antenatal education which may, in fact, be different. If an expectant parent attends antenatal classes it may not be in order to have, for example, a shorter labour, or avoid an instrumental delivery, therefore the traditional measures of effectiveness may not be appropriate in this instance. These three categories are now examined in more depth.

Physical Outcomes of Labour and Childbirth.

Conflicting results have emerged from studies attempting to measure how antenatal education may have an effect on the physical outcomes of childbirth and labour. It is very difficult to measure the effect that antenatal education has on these issues. There are so many other factors involved in the physical outcome of labour and childbirth , including labour ward protocols, attitudes of midwives and obstetricians for example. This may offer some explanation for these conflicting findings. Traditional measures identified by Nolan (1994), such as the rate of assisted or operative delivery, length of labour and analgesia used, are all affected by these other factors making a relationship between antenatal education and physical outcomes difficult to establish. Attitudes and policies within the labour ward can swamp the effects of antenatal education. There are so many other variables to consider e.g., if one considers the length of labour, who says that a six hour labour is 'better' than a twelve hour labour? Again it is difficult to understand who sets the standards by which these measures are taken, and it is also difficult to measure the 'easiness' of the labour. A study cited by Butler (1985) which

was carried out in New Zealand in 1984 by Gunn et al found no evidence that attending antenatal classes will ensure an easier or less complicated birth. This was the conclusion after studying patterns of childbirth at several large Auckland hospitals. This study showed statistically significant longer stages and more operative procedures in class attenders, but postulated that the self-selection bias that tended to put women more likely to have problems (e.g. older mother, large baby) in the attender group may account for this trend. A study by Sturrock and Johnson (1990) concluded that a benefit, by attending childbirth education classes, of reducing interventions during labour and delivery was not demonstrated. It was also found in this study that there were non significant trends towards longer second stage of labour, increased use of forceps or vacuum at delivery and increased use of medication in the group that attended the classes. It was also found that a significantly higher percentage of attenders were older, better educated or of higher socio-economic status. It is possible that the nature of the two groups in some way had some influence on the findings. Sturrock and Johnson (1990), in relation to the increased use of medication by the group that attended classes, suggest that this may be due to the fact that, as educated consumers aware of the medications available during labour, they were more likely to request them. Sturrock and Johnson (1990) also found that women who had little intervention antenatally (i.e. no childbirth classes) exhibited a trend to perform better in labour. Again they are measuring performance in labour, using indicators such as length of second stage, use of analgesia and intervention during delivery. A large study by Lumley and Brown (1993) which compared attenders and non-attenders at childbirth education classes in Australia also found rare and minor differences between women who attended classes and those who did not with respect to measures of pain, use of analgesia and obstetric interventions.

None of these studies is able to evaluate antenatal education from other sources though, such as literature, individual time spent with midwives in antenatal clinics and family and friends. Lumley and Brown (1993) found that women who did not attend

classes rated family and friends very helpful in preparing for labour and delivery, but felt that this may reflect their more limited access to professional support. It may also be that preference is demonstrated to family and friend support over professional sources. Sturrock and Johnson's study (1990) found that attenders were more likely to be better educated and of a higher socio-economic group and it could possibly be that these women were also more able to get information from other sources

Shearer (1993) argues that management of labour, including induction, monitoring , pain relief and caesarean section, have been shown to follow practice habits within hospitals. Perry (1992) cites Enkin (1990) and others who argue that research findings can only point to associations between obstetric outcomes and attendance at antenatal classes, and that it would be wrong to assume a cause and effect relationship. There is a complex and interrelated structure of variables which may all serve to influence obstetric outcomes, in which childbirth classes may or may not play a part. Antenatal education can be provided in other forms apart from structured classes. Following an extensive literature review I was unable to find any studies which attempted to measure these other influences, apart from a brief mention in the Lumley and Brown (1993) study. There are also many other key variables which have an influence on outcome of labour and delivery such as access to resources, genetic factors and values and beliefs, all of which are difficult to measure.

Psychological and Emotional Outcomes.

Psychological and emotional outcomes are of particular interest because of their association with behaviours which may manifest in physiological outcomes of childbirth (Perry 1992). A study conducted by Green et al (1990) found that clients who felt they had staff support and were given the 'right' amount of information antenatally were happiest postnatally. Other findings supported the concept of the self-fulfilling prophecy. Women who expected labour to be painful were more likely to

find that it was, women who expected breathing and relaxation to help were more likely to find that it did and women who did not expect labour to be a fulfilling event were less likely to find that it was. This study used satisfaction scores to gather data. This interesting observation suggests that midwives may have an important role to play in influencing attitudes and beliefs, but the correct balance between realistic and unrealistic expectations is important. If, as O'Connor (1993) believes, attitudes, beliefs and values are often in place before midwives come in contact with their clients it may be unrealistic to expect midwives alone to have any impact on changing these ideas.

Measurement of pain involves many other factors such as culture and class which may also influence womens' perceptions of pain. Attitudes towards childbirth as a fulfilling event are personal and individual and must also involve many other variables such as culture and beliefs which are in place before any contact with midwives is made. Family structures have developed in a way which often excludes nurturing of child care competencies within the family with support from the family network. These wider social and political issues may themselves influence the psychological and emotional outcomes of childbirth.

Choice and control are two very important psychological and political issues. 'Changing Childbirth' (DoH 1993) calls for more consumer choice and control in childbirth. If, as is advocated in the Report, women are offered informed choice and control, it may improve their mental health and, one might argue, liberate rather than oppress. A study by Skevington and Wilkes (1992) involving a sample of the pregnant population who attended childbirth preparation classes found that those who elected to attend an alternative to the more traditional NHS classes showed evidence of better mental health, especially in terms of fewer depressive symptoms. This study did not, however, make any comparisons with pregnant women who chose not to attend any classes. The authors predicted that women who chose to attend 'alternative' childbirth classes were more likely to be more concerned with being in personal control of other

events. They postulated that women attending 'alternative' classes might also be more mentally healthy. An interesting observation of this study is that the attenders of the NHS classes were not as highly educated as the attenders at the alternative classes who were more likely to be middle class with tertiary education. Measurements of self esteem and the extent and intensity of depressive symptoms were made using questionnaires after the penultimate class. No measurements were made prior to commencement of the classes to gauge if the classes themselves had any effect on these measurements. It may be that women with more formal education coming from a middle class background may be more able to express their wishes over matters of choice and control and may be more mentally healthy before commencement of the classes. This study also found that the NHS group had fewer positive expectations about childbirth and a substantial proportion expected labour to be painful (Skevington and Wilkes 1992). These authors conclude that low levels of self esteem and symptoms of depression are characteristics of feelings of helplessness associated with low levels of perceived choice. The study used beliefs about pain in labour as a measure of expectations of birth. It may be the case that the belief that labour is painful is a realistic belief rather than a negative expectation. This study was one of a limited number found during the literature search which attempted to measure the psychological impact of childbirth classes. Critical evaluation of this study identifies several flaws in its conclusions. The benefits and effects of antenatal education on psychological and emotional outcomes of childbirth are very difficult to measure quantitatively. There is anecdotal evidence to suggest that women find antenatal education beneficial to their psychological health, but there are so many other interrelated factors involved in the process of childbirth that possibly in an effort to measure the benefits of antenatal education quantitatively, much of the research involves measurable outcomes such as perinatal and maternal mortality and morbidity.

Levels of Knowledge and Confidence.

The benefits and effectiveness of antenatal education have also been measured using assessment of knowledge levels before and after attending classes. This may give an indication of effectiveness from the health professional's viewpoint, but has little to do with the needs the mothers brought to the classes (Nolan 1994). Every prospective parent has a different level of knowledge, different needs and different expectations. Antenatal education can perhaps only be regarded as effective if it attempts to meet and address those needs.

As Hillier and Slade (1989) point out, several of the studies which considered the impact of classes on knowledge have included a variety of methodological flaws. Some studies have assessed levels of knowledge after birth rather than on completion of classes, and have made no measure of knowledge prior to commencement of classes. Often attenders have shown higher levels of knowledge than non-attenders, but attenders have often also been of a higher socio-economic class which may have some bearing on the results (Hibbard et al 1989). People derive knowledge from many different sources such as magazines, books, television, friends and family. It may be possible that people who attend antenatal classes are motivated to gain this knowledge and would get it from other sources even if they didn't attend the classes.

Hillier and Slade (1989) report that a major aim of antenatal teaching is to increase confidence in coping with labour and the care of an infant, but it is not apparent how this aim has been identified and there has been little research relating to this topic. They attempted to assess the impact of antenatal classes on knowledge and confidence levels. The participants in this study were all expecting their first child. They found that knowledge and confidence levels showed a substantial increase over the period of the classes. They did not use a non attender group with which to compare the findings though, so it is difficult to determine a cause and effect relationship. Their findings

did, however, suggest that the impact of classes reduced the difference in knowledge attributable to an individual's social and educational background, although it would be difficult again to determine how much knowledge would have been derived from alternative sources. This study, although fairly small scale (67 participants) did have some interesting findings regarding levels of knowledge and confidence and anxiety. There was found to be a significant correlation between knowledge and confidence for labour at the final assessment which was completed at the end of classes, as compared to initial assessment prior to the start of the first session ($r = 0.45$, $p < 0.001$) but not for confidence about child care ($r = 0.05$ NS) . They suggest that this may be because labour and infant care are perceived as discrete stages in a process, and that labour and delivery have to be experienced before knowledge of child care can have any practical advantage. This finding, if confirmed in other similar studies, could have strong implications for the subjects covered during antenatal education. Midwives may ask themselves if there is an advantage in covering aspects of baby care antenatally, or whether these topics should perhaps be covered more thoroughly during the post natal period. The implications could be that more post natal education and support through, for example post natal support groups, should be made available.

Hillier and Slade (1989) also commented on the lack of relationship between anxiety and knowledge from the findings of their study. They found that although knowledge levels increased over the course of the class, anxiety showed no change. They postulated that this was due to increasing anxiety as labour approached counteracted by an increase in knowledge to maintain apparent stability. As pregnancy and childbirth is a major life event for most people, it would be hard not to expect prospective parents to be anxious. Whether increased knowledge can have a positive effect on anxiety was not established in this study. Other studies have found that there is no evidence to indicate whether the woman's or her partner's confidence and coping ability is influenced by childbirth education (Walker and Erdman 1984). There is also evidence to suggest that women do not regard antenatal classes as their best source of

information and advice (Jacoby 1988). In a study by Sullivan (1993) all the participants (71 Canadian primiparas and multiparas) indicated that their first source of information about childbirth and childrearing was their friends and colleagues, and also the reading of books, magazines and pamphlets to gain information. These findings again question whether increased knowledge is derived mainly from antenatal education sources provided by health professionals or whether provision of knowledge is sought from other sources.

Studies that have attempted to measure effectiveness and benefits of antenatal education have concentrated on antenatal classes. Antenatal education can often be provided in clinics and other places by midwives. The tools used to measure effectiveness and benefits are dependent on the assumptions made about the aims of antenatal education. According to Freire (1972) the education process can oppress or liberate. The implications of Changing Childbirth (DoH 1993) would appear to be that the antenatal education process should empower, thus liberate, parents. Antenatal education also needs to be able to identify the needs of the clients in order to be beneficial to those clients. The next chapter examines whether midwives identify and meet clients needs in relation to parenthood preparation.

CHAPTER FOUR

Midwives as Educators.

In the previous two chapters the aims of antenatal education and the benefits and effectiveness of antenatal education have been examined. It appears that there are many differing and sometimes conflicting aims which are often not clear. Effectiveness has also been measured in many different ways with conflicting results which have at times led to people questioning the need for antenatal education. This chapter examines whether the apparent lack of clarification of the aims of antenatal education and conflicting findings regarding benefits and effectiveness may be due to poor preparation of midwives as educators, or may involve more fundamental issues such as whether traditional antenatal education is needed or necessary and if it should have a place in today's midwifery service in its present form.

Rees (1993) believes that the quality of antenatal classes depends greatly on the skills of the midwife responsible for the class. He says that a number of midwives have admitted that they hate standing in front of a group, yet most midwives working in the community are expected to provide antenatal classes for their clients. The consequences are that the midwives are unhappy in their role and this may be passed on to the clients. This can only have a negative effect on the sessions. This article does not examine wider issues such as how antenatal education should be approached. Possibly if antenatal education had clear, widely recognised aims and purposes it would be easier to help midwives recognise and accept their role as educator. There are no suggestions as to any possible reasons for the unhappiness of some midwives to teach groups but this may be one. Because of the differing aims of antenatal education it must be very difficult to prepare midwives adequately for this role. Robinson and Thomson (1991) say that studies suggest that staff feel inadequately prepared for a teaching role. They cite a study by Robinson, Golden and Bradley (1983) which found

that just over a quarter of midwives surveyed said that they did not feel adequately prepared for teaching responsibilities. Turner (1993) also says that often the prospect of being faced by a group of interested learners terrifies some midwives, due, she believes, to the lack of preparation for this role. If a midwife is unhappy with her role as educator it is may be that she might also lack motivation to take on this role. According to O'Connor (1993) the most important factor is that whoever is the educator should enjoy the role and be motivated to perform well. Unhappiness in the role and lack of motivation can lead to a perpetuating circle of poor quality education. She states that education of the educators is of the utmost importance and that they should keep up to date with issues and research which may effect the quality of the service they offer. The findings of the study in Chapter Five were that 13.7% of the midwives who responded held a teaching qualification / certificate. In the same study 82.4% of respondents had received training in teaching skills as student midwives and 33.3% had received training in teaching skills since qualification. It was not possible to ascertain the quality of the training. Hancock (1994) also says that a midwife should retain the motivation to seek information constantly to enhance her/his knowledge and midwifery skills, and suggests that teaching skills may be out of date or may not be used adequately, leading to lack of confidence in midwives as educators and ultimately to a decline in competence. All these studies imply that the education of midwives for their role as educators is very important, but midwifery education needs to recognise this in order to facilitate midwives' roles to provide a valuable service in antenatal education - both for the clients and the midwives.

Midwifery Training.

Turner (1993) states that provision is made during the eighteen month midwifery training for the midwife's role as providing

> a programme of parenthood preparation and a complete preparation for childbirth, including advice on hygiene and nutrition (UKCC 1994).

The issue is whether this provision is adequate . Often this means only a two hour session on the theory of teaching in clinical practice and a minimum of two half hour tutor observed practical sessions of teaching in the clinical situation. This would appear to be extremely minimal in relation to the eighteen months training that midwives undertake. Often, as Murphy-Black and Faulkner (1991) say, midwives learn by 'sitting next to Nellie' or they base their own teaching practice on their learning experiences. Until recently, both basic and post-basic teaching has been lecture based and teacher-led which often precludes questioning by students (certainly this was the case during the majority of my midwifery training from 1988 - 1990). This didactic approach may be the only experience of teaching style that midwives have had on which to base their own teaching style.

My own personal preparation for the role of educator involved very little time spent on theory relating to teaching in clinical practice with some practical observation of a midwife conducting six parentcraft sessions. I also had to conduct a session myself at the end of my training. The experience of my fellow student midwives at the time (1988 - 1990) was very similar.

The way in which midwives approach antenatal education may also be based on assumptions behind traditional antenatal classes which are identified by Gilkeson (1991) and cited by Walsh (1993) as -

> The midwife is the expert, in possession of knowledge that will help women to experience a happy and safe birth. If women listen, learn and apply this knowledge, birth and parenting will be easier than if they had not attended classes. The knowledge is best communicated by a didactic method, although breathing and relaxation therapy are best demonstrated practically.
>
> (p.120)

These assumptions are contrary to the recommendations of Changing Childbirth (DoH 1993) which calls for consumer choice, control and empowerment and

demonstrate Freire's banking concept of education. Thomas (1995) cites Rappaport (1984) who defines 'empowerment' as a process by which people (or organisations) gain mastery over their lives. Traditional antenatal education often appears to encourage conformity and compliance in the women. This type of education encourages the view that the service should dictate the terms and women are the passive recipients of the care they receive. This appears to illustrate Freire's concept of education serving to oppress rather than liberate the clients. It does nothing to empower women. By demonstrating how current issues can be contrary to traditional assumptions it is evident how important it is that midwives have a responsibility to keep themselves up to date with developments and to examine their role as educators.

An example of this concept is an article written by Thomas (1995) which examines the concept of empowerment in relation to the baby bath demonstration referred to earlier which is included in many antenatal classes and is still a part of the post natal care given to women on the unit where I work. Thomas (1995) examines the procedure and concludes that the control is firmly with the midwife, and as she points out, this control is often reinforced with the promise that the woman will be observed performing this ritual herself to make sure she can cope at home. This is one example of the many habitual routines which are apparent in midwifery care. If, as Changing Childbirth (DoH 1993) suggests, midwives should be giving choice and control to women, midwifery training should perhaps educate midwives in ways, as educators, that they can help to empower women.

From personal experience, and from questioning students, it does not appear evident at this time that the responsibility as educators is recognised as being fundamental to the issue of empowerment. This is, however, a personal observation with which some people might not agree and which possibly warrants further investigation.

Student Midwives Accounts of their Experiences of Preparation as Educators.

I was able, through informal interviews, to ascertain the views of two student midwives and a newly qualified midwife regarding their perceived preparation to take on their role as educator. The interviews were semi - structured and lasted about ten minutes. All three participants attended the same School of Midwifery, so it should be recognised that the information gained cannot be viewed as representative of all student midwives from that particular school of midwifery or elsewhere. I do consider however that this information is a valuable base on which further study may be initiated.

Format.

Each person was spoken to individually in the workplace. The purpose of the interview was explained, and then each person was asked how much preparation they had received during their training for a teaching role. One student was half way through her training but had only three weeks of formal lectures to attend, and as far as she was aware, no sessions on theories of teaching/learning or teaching skills were to be included during this time. The other student was just completing her training and she, when asked the same question, was unable to identify any times during her training when teaching skills or theories relating to teaching were addressed. The midwife who was newly qualified (within the last twelve months) was also unable to identify any formal addressing of teaching skills during her training. When asked what preparation they were given in order to take antenatal classes, they all said that they observed community midwives taking the classes during their community placement, and were then expected to take the antenatal classes themselves at the end of their training, observed by the community midwife they were allocated with. When asked

to identify areas during their training when they may have been prepared for an educator's role they all felt that possibly the seminars which they were all expected to present may have helped their presentation skills. They were given feedback after the seminars, but the value of the feedback relating to their ability to talk to a group of people was limited. All three had received their training from the same School of Midwifery so their answers were similar.

These three interviews illustrate what the search of literature has found, that most training in teaching skills is gained from 'sitting next to Nellie', that is by example from other midwives who in turn may themselves have not had any formal training in teaching skills.

The next chapter is a report of a study which I carried out using questionnaires to try and ascertain how well midwives felt they were prepared as educators. The study looks at midwives' perceptions of clients needs for preparation for parenthood and also examines clients' beliefs about preparation for parenthood.

CHAPTER FIVE

Primary Study

Introduction

I wanted to look at midwives feelings about the amount of preparation they receive to deliver antenatal education, and to identify their perceptions about the important subjects which should be included in antenatal education. I also asked clients what they felt were important subjects which needed addressing in antenatal education. From this I compared and identified whether midwives' perception and clients' needs were matched. I also wanted to find out where both midwives and clients would prefer to deliver and receive antenatal education.

I decided to use questionnaires in this survey. They are less costly, less time consuming and can offer anonymity, which I felt was important for this particular study as possibly respondents would be more likely to answer the questions truthfully. This study utilised a cross sectional survey design to assess :-

a. The level of attendance at antenatal classes.

b. What midwives perceive to be the antenatal education needs of parents.

c. What clients identify as their antenatal education needs.

d. How clients and midwives would prefer to receive and deliver antenatal education.

e. How midwives feel about the amount of training they receive to enable them to identify and meet the educational needs of client.

Sample.

Two questionnaires were devised, one for midwives and one for mothers. The questionnaires for midwives (appendix i) were addressed to all practising midwives employed by a Trust either within the hospital or in the community. They were left in the appropriate work area for the midwives. A questionnaire was sent by post to all women whose baby was born during a two week period commencing 29th August 1994 (appendix ii) and 27th February 1995 (appendix iii). Stillbirths and premature births prior to 34 weeks gestation were excluded from the study to avoid any additional upset to the parents. I also wrote to Health Visitors in each area asking them to identify any further women they did not feel it appropriate to include in the study, e.g. women whose babies had subsequently died. The questionnaires had return by dates in an attempt to facilitate return. The sample size of 177 compares with the average birth-rate in that area of 2,500. Working on an average of just over 200 births a month my aim was to get a sample size of approximately 200 but the two week period in August/September 1994 was below this average.

Instrumentation.

The questionnaires used a range of mainly closed ended questions. There was a selection of dichotomous questions, graphic rating scale questions and rank order questions. Closed ended questions were used to ensure comparability of responses, although it was recognised that a major drawback is the possibility of neglecting or potentially overlooking some important responses. With this in mind an opportunity for respondents to include their own comments was given in order to collect some qualitative data.

Midwives Questionnaire.

The questionnaire to midwives was tested on 5 colleagues initially to ensure that it would be understood. No problems with either questionnaire design or questions were identified. The aims of this questionnaire were threefold.

1. To ascertain the level of training midwives feel they have received in teaching skills.
2. What their perceptions are of the most important subjects which should be included in antenatal education, and what they perceive to be the clients needs.
3. How often they think their teaching skills should be updated.

The opening paragraph briefly explained what the aim of the study was, and also said that the midwives would get feedback about the results of the study which it was felt may motivate them to complete the questionnaire. The questionnaires were put into envelopes addressed to each midwife and left in the appropriate work area. Collection trays were left in each area to facilitate return.

Clients' questionnaires.

I decided to send a questionnaire to all mothers who had their baby in the Trust area 3 months ago and 9 months ago from the date of posting the questionnaires. This decision was in order to see if feelings changed about the antenatal education clients received as their baby started to develop and they began to encounter different experiences and problems. I also did not want to send questionnaires out to women who had babies longer ago than this period in case their recall of events was not as good and also in case this adversely affected response rates. Any earlier than 3 months after delivery may have been too soon for life to settle down and reflection to occur and again may have adversely affected response rates.

Both questionnaires were designed to elicit the maximum amount of information whilst maintaining a simple form to try to encourage a good response rate. The opening paragraph of the questionnaire explained who I was and what I was doing. It also assured clients that they were under no obligation to complete the questionnaire. A contact number of the Midwifery Manager was also included for anyone who wished to check that the study was approved.

Ethical Approval.

Ethical approval was sought and granted by the Ethics Committee. A protocol was submitted prior to the Committee meeting which I was required to attend to answer any queries the committee might have. Written approval then followed. (Appendix iv).

Participation.

Participation was on a purely voluntary basis in that return of completed questionnaires confirmed participation. Any person not wishing to be involved in the study would not complete the questionnaire. As all the questionnaires were anonymous there was no way of identifying respondents and non-respondents.

Limitations.

It is recognised that this is only a small scale local study which may not be representative of the whole population. Although I had relatively good response rates to the postal questionnaires it is also uncertain whether these findings were representative of the sample. As Polit and Hungler (1993) point out, people who complete questionnaires are rarely a random subset of those of the sample. It may

possibly be that mainly motivated people responded , or people with strong views which may introduce bias into the finding. As there was no way of identifying respondents I had no way of sending reminders to non-respondents which possibly may have improved response rates, but I wanted to assure people of anonymity.

The postal questionnaires were addressed to the mothers. It was recognised that by doing this the fathers' perspectives may not be included, but unfortunately the birth records I had access to only contain the name of the mother and do not give details of marital status and partners.

Nolan (1994) points out that there is a shortage of research to establish mothers' agenda for antenatal education. This study attempts to identify this agenda by asking women to identify and rank what they believe are the six most important subjects which should be included in antenatal education. I devised the list of subjects so may have not included subjects which women may wish to address. To try to overcome this potential problem I asked for any subjects not included to be identified by the respondents.

RESULTS

Response Rates

Table No. 1

respondents	questionnaires sent	returned not delivered	returned completed	response rate %
Midwives	84		51	60.7 %
August 1994 group (group a)	75	3	36	50.0 %
February 1995 group (group b)	109	4	55	52.4 %

The midwives' main work area was identified as this may have affected the answers given in the questionnaires. In the unit where this survey took place, it is the community midwives who have the main responsibility for antenatal education either in the clinics or at antenatal classes, whereas staff working on Delivery Suite have a limited input into antenatal education. It was interesting, therefore, to note response rates from each work area as indicated in Table 2.

Table 2 - Main work area of midwives

Main work area	questionnaires sent	questionnaires returned	response rate
Wards	45	31	68.9%
Delivery Suite	8	7	87.5%
Community	22	12	54.5%

1 respondent did not indicate area of work

This shows that the best response rates came from the hospital staff who possibly may have the least involvement with antenatal education. It was no more difficult for the community midwives to return their questionnaires as there is a convenient internal posting system as well as regular returns of medical notes by taxi. It is therefore difficult to postulate the possible reasons for the differences in response rate from the main work areas.

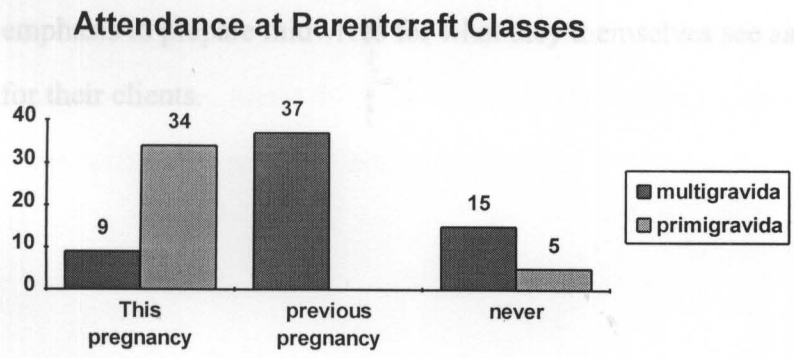
The response rate was quite high for a questionnaire. (Sapsford and Abbot 1992 consider a 50% response rate as high).It could indicate midwives' motivation about wanting to improve their service, and was encouraging with respect to the design of the questionnaire itself, as possibly a complicated or time consuming questionnaire would be less likely to be completed and returned. Three questionnaires were also returned after the data collection had been completed which would have improved the response rate further.

Length of time since training.

Midwives were asked to indicate when they qualified. Of the respondents 27 midwives have been qualified for over 10 years, and 24 midwives have been qualified for 10 years or less. Midwives have to attend a statutory refresher course every five years and have a professional duty to maintain their practices and knowledge. Until April 1995 there was no check made of midwives' updating, so it has been up to each midwife how well she/he updates herself / himself. This could have implications for the antenatal education received by her/his clients, as many areas of antenatal education have changed and developed and continue to do so.

Attendance at Parentcraft classes.

Clients were asked to indicate whether they had attended parentcraft classes during this pregnancy and, in the case of multigravida women, whether they had attended parentcraft classes during any previous pregnancies. The response to this question would not be affected by the time of delivery so the responses of the August 1994 group and the February 1995 group have been combined. Of the respondents, 39 were first time parents and 52 were expecting their second or subsequent baby.



As can be seen from the graph the majority of attenders at parentcraft classes during this pregnancy were primigravida (79.1 % of respondents) with 20.9 % of attenders multigravida. 71.1 % of multigravida women had attended parentcraft classes during a previous pregnancy. 21.9 % of respondents had not attended parentcraft classes at all. If parentcraft classes are the main vehicle for delivery of antenatal education by midwives these women may have missed an opportunity of receiving it.

How important midwives feel antenatal and early parenthood education is.

Before examining midwives' perceptions of clients' needs and also the needs identified by the clients themselves regarding antenatal education midwives' beliefs about the importance of antenatal education are examined. The midwives were asked to indicate how important they felt antenatal and early parenthood education is. They had a choice of not important, fairly important, important or very important. The majority of midwives who responded believed that antenatal education was important or very important (94% of respondents). When this fact is compared with the number of midwives who have a teaching qualification and have received training in teaching skills (see Tables 4 and 5)one conclusion could be that there is a need for more emphasis to prepare midwives for what they themselves see as an important service for their clients.

What midwives perceive to be the needs of clients and what clients identify as their antenatal education needs.

Midwives and clients were asked to indicate the six most important subjects in order of importance, 1 = most important etc. A value of six was given to the most important subject indicated , 5 to 2nd, 4 to 3rd, 3 to 4th, 2 to 5th and 1 to 6th. This was done to try to identify more clearly the difference in importance attached to the subjects, both by midwives and by the clients and is intended to indicate how much or how little importance is attached to each subject. Midwives were asked to indicate the subjects they believe clients most want information about (mr (inf)) and also what the midwives themselves believe to be the most important subjects (mr (imp)). The two groups of clients are compared to examine whether needs change as the baby becomes older. The two client groups are clients (a) whose babies were nine months old when they received the questionnaire, and clients (b) whose babies were three months old when they received the questionnaire. Included in the following table which enables direct comparison are % frequency chosen (f). As each group had different numbers of respondents a percentage of the possible total was worked out for each group to enable comparisons to be made. Mean rank score (s) is the value arrived at when the total value of the subjects when values are applied to the ranks given is divided by the total number of times the subject was chosen. Range (r) denotes the range of rank each subject was given, mode rank (m) is the rank most frequently attached to each subject and overall score (o) is a score derived by multiplying the % frequency chosen by the mean rank score. Again this was done to enable direct comparison between groups when each group was a different sample size.

Table 3 - subjects identified as most important.

Subject	% frequency chosen (f)	mean rank score (s)	range (r)	mode rank (m)	overall score (o) (o = f x s)
Labour and delivery					
mr (inf)	100.0	5.7	1 - 5	1	570.0
mr (imp)	82.3	4.1	1 - 6	1	337.6
clients (a)	91.7	5.1	1 - 5	1	467.6
clients (b)	89.1	4.7	1 - 6	1	423.6
Pain relief during labour					
mr (inf)	98.1	4.7	1 - 6	2	461.0
mr (imp)	80.4	3.6	1 - 6	2	289.4
clients (a)	97.2	3.4	1 - 6	2	327.7
clients (b)	87.3	3.6	1 - 6	2	314.3
Relaxation and breathing					
mr (inf)	68.6	3.1	1 - 6	3	212.6
mr (imp)	56.8	3.6	1 - 6	3	204.7
clients (a)	41.7	4.0	1- 6	3	166.8
clients (b)	41.8	2.5	2 - 6	4	105.4
Complications during labour and delivery	60.8	2.4	2 - 6	6	145.9
mr (inf)	43.1	2.4	2 - 6	6	101.8
mr (imp)	66.7	3.9	1 - 6	2	258.4
clients (a)	72.7	3.4	1 - 6	2	245.3
clients (b)					
Antenatal investigations					
mr (inf)	60.8	3.7	1 - 6	4	224.9
mr (imp)	68.6	4.5	1 - 5	1	308.8
clients (a)	44.4	4.4	1 - 6	1	194.2
clients (b)	54.5	3.8	1 - 6	1	208.9
Complications during pregnancy					
mr (inf)	35.3	2.4	2 - 6	5	86.3
mr (imp)	21.6	3.5	1 - 6	2 & 4	76.6
clients (a)	50.0	4.1	1 - 6	2	205.0
clients (b)	70.9	3.4	1 - 6	2	241.1

Breast and bottle feeding					
mr (inf)	70.6	2.7	1 - 6	6	190.6
mr (imp)	76.5	2.4	1 - 6	6	183.5
clients (a)	36.1	3.0	2 - 6	5	108.3
clients (b)	43.6	2.2	1 - 6	5	95.9
Minor disorders during pregnancy					
mr (inf)	33.3	2.8	1 - 6	3	94.0
mr (imp)	25.5	3.7	2 - 6	2	94.1
clients (a)	22.2	2.2	3 - 6	5	49.9
clients (b)	30.9	3.2	1 - 6	3	99.9
Changes within the family					
mr (inf)	13.7	2.1	4 - 6	4	29.3
mr (imp)	41.2	3.6	1 - 6	1	149.1
clients (a)	33.3	2.2	2 - 6	6	74.9
clients (b)	29.1	2.2	1 - 6	6	65.5
Role of the midwife and health visitor					
mr (inf)	11.8	2.0	1 - 6	6	23.5
mr (imp)	43.1	3.0	1 - 6	4 & 6	131.2
clients (a)	33.3	1.8	4 - 6	6	60.0
clients (b)	25.4	1.5	3 - 6	6	38.1
Diet during pregnancy					
mr (inf)	19.6	2.8	3 - 6	3 , 4 & 5	54.9
mr (imp)	41.2	3.6	1 - 6	3	149.1
clients (a)	33.3	2.1	2 - 6	6	69.9
clients (b)	23.6	3.0	1 - 6	5	69.0
How to bath baby					
mr (inf)	31.3	2.0	3 - 6	5	62.6
mr (imp)	3.9	1.0	6	6	3.9
clients (a)	5.5	3.5	4 - 6	5	19.4
clients (b)	7.3	1.5	5 - 6	5 & 6	10.9

2 people did not rank their choices and 1 person only ranked 5 subjects

Other subjects indicated as important included :

feelings during the post natal period

resuscitation of baby

hospital - things to take in, length of stay

information about Special Care Baby Unit

how to get into hospital

developmental milestones, behaviour

By asking midwives what they believed clients most wanted information about, and also asking midwives what they themselves believed were the most important subjects, if one were to believe that midwives followed the philosophy of identifying and meeting the needs of the clients, one would expect the data from midwives mr (inf) group to be similar to the data of midwives mr(imp). There were in fact some interesting differences which could be interpreted as meaning that some midwives may feel that they are better able to identify clients needs than the clients themselves. The six most frequently indicated subjects were the same apart from 'the role of midwife and health visitor' which midwives indicated that they believed was important but which they didn't think clients wanted to know about.

Midwives indicated that although they thought clients wanted to know about 'complications during labour' the midwives themselves thought it more important that clients should know about 'the role of the midwife and health visitor'. When comparing clients identification of needs with midwives' perceptions of clients needs it can be seen that 'complications during labour and delivery' and 'complications during pregnancy' have little importance attached to them by midwives but are indicated as more important by clients. Midwives believe 'the role of the health visitor and midwife' along with 'changes that a new baby brings' and 'diet during pregnancy' are fairly important but the clients who responded attached less importance to them. Midwives also indicated that they believed that clients wanted information on 'how to bath a baby' but clients did not indicate this. The predominant subjects for all groups were 'labour and delivery' and 'pain relief during labour'.

The fact that there were some differences in the choice of subjects that midwives believe clients most want information about and what midwives believe are most important perhaps highlights an assumption that some midwives possibly might have

that they know what the clients' needs are better than the clients themselves. When comparing the two groups of clients the group whose babies were older (group a) ranked 'changes within the family that a new baby bring' slightly higher in importance and 'minor disorders during pregnancy' lower in importance than the group whose babies were three months old. This could be a possible indication that as a baby gets older subjects may seem to become more or less important. There were not any major differences in needs though. Group a did not indicate the importance of the subject 'the role of the midwife and health visitor' as consistently as the February group (group b).

These findings contradict Chalmers and McIntyre (1994) who say, as stated in Chapter Two, that more emphasis should be placed on preparation for parenthood rather than childbirth and backs up the findings of the study by Nolan (1994) which found that no one in a post natal group indicated that they had worries about bathing, changing or feeding their baby. Ford (1994) identified in chapter two as saying that needs and provisions are mismatched is contradicted with regard to subjects indicated as most important to both midwives and clients.

When clients were asked to indicate where they received advice and information about the subjects identified it was found that 'labour and delivery' and 'pain relief during labour' were the subjects which were most often addressed at parentcraft classes, with 'antenatal investigations' and 'minor disorders of pregnancy' most often addressed during clinic or home visits. From the data it would seem that 'labour and delivery' and 'pain relief during labour' are not addressed very frequently during clinic or home visits which may possibly mean that women who do not attend parentcraft classes may not have the opportunity to discuss these subjects. Overall it would appear that 'labour and delivery' and 'pain relief during labour', which were identified both by midwives and clients as the subject information is most wanted about antenatally, are the subjects most frequently addressed.

The subjects that the clients ranked as 1st and 2nd were analysed and responses from the primigravida and the multigravida were compared to see if there was any difference.

Responses from group a :

Labour and delivery was ranked 1st overall. 64.7% of primigravidas ranked it as the most important subject. 52.9% of multigravidas ranked it as the most important subject. 70.5% of both the primgravida and multigravida group ranked this subject as either 1st or 2nd. This fact indicates that when women have experienced labour and delivery they still want information about it when they are pregnant again.

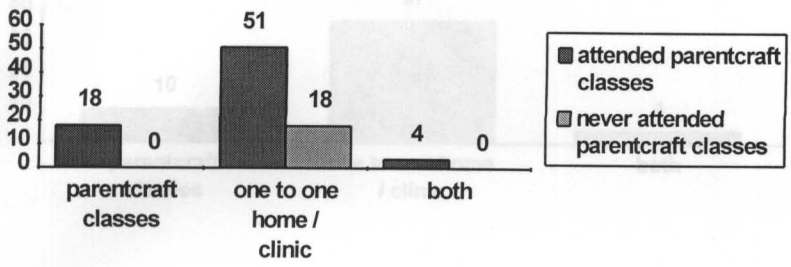
Responses from group b :

Labour and delivery again ranked 1st overall, with 40% of primigravidas and 33% of multigravidas ranking it as the most important subject. 75% of primigravidas ranked this subject as either 1st or 2nd, whilst 46.6% of multigravidas ranked it as 1st or 2nd. It is unclear why there is some disparity between the figure of 46.6% and the figure of 70.5% of multigravida in the August 1994 group.

How clients and midwives would prefer to receive and deliver antenatal education

Clients were asked how they would prefer to receive information and advice about pregnancy, childbirth and early parenthood. They had the options of (a) at parentcraft classes, (b) during clinic / home visits with your midwife or (c) other.

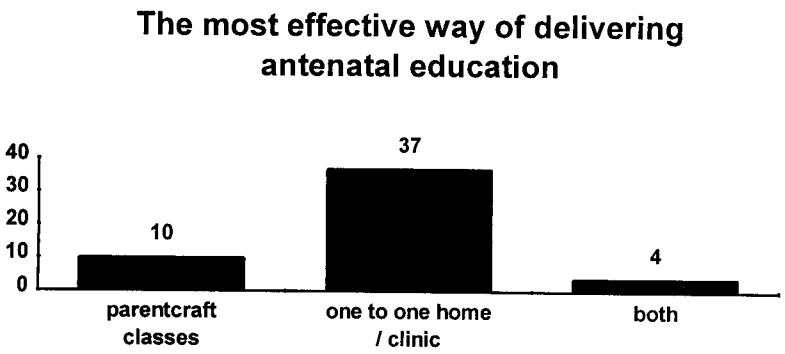
Where clients would prefer to receive antenatal education



This set of data shows that 19.8 % of respondents indicated that they would prefer to receive antenatal education at parentcraft classes, and all these respondents had previously attended parentcraft classes. A total of 75.8 % of respondents indicated that they would prefer to receive antenatal education on a one to one basis at home or clinic, and of these 74 % had previously attended parentcraft classes. 4.4 % of respondents indicated that they would prefer to receive antenatal education both at parentcraft classes and on a one to one basis at home or clinic.

Midwives responses.

Midwives were asked to indicate which, in their opinion, was the most effective way of providing information and advice for clients. They also had the options of (a) parentcraft classes (b) one to one in clinic / home or (c) other.



It would appear that the majority of midwives who completed questionnaires felt that the most effective method of providing antenatal education was one to one either in the client's home or at antenatal clinic. Only 19.6 % of midwives felt that parentcraft classes alone were the most effective way of providing antenatal education. This figure could be influenced by midwives' feelings about delivering antenatal education in a group setting and on a one to one basis. For instance if a midwife felt uncomfortable in a group setting it may bias her response. These findings compare with Haralambos and Holborn (1995) and Freire (1972) who are discussed in chapter two. Haralambos and Holborn (1995) say that liberal education focuses on individual needs whilst Freire (1972) believes that the didactic method of passing on information, which is commonly the method used at parentcraft classes, only serves to oppress the audience. It would seem that both clients and midwives would prefer to receive a more liberal approach to education.

Midwives feelings about the training they receive to enable them to identify and meet the educational needs of clients.

Midwives were asked to indicate whether they held a teaching certificate/qualification and whether they had received training in antenatal and early parenthood teaching as a student midwife and since qualifying.

Table 4 Do you hold a teaching qualification/certificate?

Answer	number	percentage
yes	7	13.7
no	43	84.3
not indicated	1	2.0

This table shows how few of the respondents actually hold a teaching qualification. The WNB 997/998 Teaching and Assessing in Clinical Practice is available within the Post Registration Department but individuals have to be nominated by their managers. Attendance at such courses is, unfortunately, subject to economic and staffing constraints, which may account for the small number of people who hold a teaching qualification. Staff themselves also need to be motivated to undertake post registration study. This study does not allow for suggestions of possible reasons for the lack of further training in this area.

Table 5 - Have you received training in antenatal and early parenthood teaching (a) as a student midwife (b) as a qualified midwife?

	Student		Qualified	
	number	**percentage**	**number**	**percentage**
yes	42	82.4	17	33.3
no	7	13.7	28	54.9
not indicated	2	3.9	6	11.8

A large proportion of midwives (82.4%) said they had received training in teaching skills as student midwives. This study was not able to find out what the perceived quality of the training was, which is an important issue. 13.7% of respondents indicated that they had received no training in teaching skills as student midwives. This factor is of concern as the Midwife's Code of Practice (UKCC 1994) states that part of a midwife's responsibilities is to provide a programme of education for parenthood. 3 respondents (5.9% of respondents) said they had never received any training in teaching skills, either as student midwives or since qualifying. One of these respondents had been qualified since 1983, one since 1990 and the third since 1993.

33.3% of midwives said they had received some training in teaching skills since qualifying, whilst 54.9% said they had received none. Again the study did not give any indication of perceived quality of this training. The midwives who said they held a teaching qualification will be included in this group unless they held the qualification before training as midwives, which it was not possible to determine.

Discussion

The response rates were generally fairly good. The midwives' response rate of 60.7% was the best, but the midwives were able to return the completed questionnaires with more ease and were perhaps more motivated to help a colleague. Non-response rates to postal questionnaires are generally very high. Sapsford and Abbot (1992) consider a 50% response rate as quite high for a postal survey. My response rate of 51.4% overall, with 50% for the 29th August 1994 group and 52.4% for the 25th February

1995 group may be considered as satisfactory, although it could introduce bias into the data if respondents are not a random subset of the sample.

The findings regarding attendance at parentcraft classes confirmed that the majority of attenders were first time parents (79.1% compared to 20.9% of multigravida). This agrees with Miles (1991) who, as indicated in Chapter One, says that antenatal classes are mostly attended by first time mothers. Fairly high proportions of women (21.9%) participating in this study chose not to attend structured antenatal classes - 20.8% of primigravida had not attended classes, and 28.8% of multigravida had never attended classes. This has important implications for midwives who may need to explore other ways of ensuring that the educational needs of these women are met adequately. All groups chose 'labour and delivery' and 'pain relief in labour' as the most important subjects. When applying values to the choices, 'labour and delivery' came first in every group. There were slight differences in what midwives believed to be important subjects and what they believed clients most wanted information about. I wanted to identify if midwives thought that 'they knew better'. The slight differences show that midwives possibly make assumptions about what they feel clients should be given information about, and are perhaps identifying client needs from a provider's perspective as opposed to a consumer perspective. If midwives believe that they are meeting client needs with regard to antenatal education, one might expect the two tables to be exactly the same. A rather provocative thought might be that it would appear that possibly some midwives are assuming that they know what client needs are better than the clients themselves.

'Labour and delivery' and 'pain relief during labour' were chosen as the important subjects by midwives and clients alike. They were also the two subjects that midwives' identified as the subjects clients most want information about. The differences between needs identified by clients and perceived needs of clients by midwives are generally slight which hopefully is an encouraging sign. It would appear from this

study that overall the educational needs of clients antenatally are being identified and met by midwives. The interesting points identified from this study are that a majority of both clients and midwives would prefer to deliver antenatal education on a one-to-one basis in the clinic or home setting. It would also appear that there is a need for more training for midwives in teaching skills. The following key points have been highlighted in this study :

i. The majority of women attending structured antenatal classes are first time parents, so there appears to be a need to ensure provision of antenatal education for multigravida women, ensuring that aims of the education are clear.

ii Not all women choose to attend antenatal classes so alternative modes of delivery of antenatal education should be explored further.

iii. Most women indicated that they would prefer to receive antenatal education on a one-to-one basis.

iv Most midwives expressed a preference for delivering antenatal education on a one-to-one basis.

v. A need to provide training for teaching skills has been identified.

Several further studies could be continued, eg. identifying fathers' antenatal education needs, examining more closely the quality of teaching skills training provided for student and qualified midwives and exploring alternative methods of providing antenatal education. With the recommendations given in Changing Childbirth (DoH 1993) attempts should be made to ensure that antenatal education liberates women, enabling them to make choices and take control of the process of childbirth.

CONCLUSION

The question as to whether antenatal education should be assumed to be an integral part of the midwife's role is answered explicitly within the Midwife's Code of Practice (1994) which, as previously stated, says that a midwife's activities should include the provision of a complete preparation for childhood, including advice on hygiene and nutrition. This is a stated duty of a midwife so therefore the assumption that the provision of antenatal education is an integral part of a midwife's role is correct. The assumption which, after surveying the literature is apparently flawed, is that midwives, by the very fact that they have undergone midwifery training successfully, are able to provide that education competently and effectively. The Midwives Rules (1993) section 33 Outcomes of programmes of education leading to admission to Part 10 (Registered Midwife) of the UKCC register states that programmes of midwifery education should include 3c(iii) 'the ability to assess, plan, implement and evaluate within the sphere of practice of the midwife to meet the physical, emotional, spiritual and **educational needs** of the mother and baby and family' (p13) . The findings of this study are that the aims of antenatal education are not clear, effectiveness is measured differently with often conflicting results and midwives often believe they are not adequately prepared for their role as educators and indeed some midwives are not happy with this role. This may lead one to the conclusion that midwifery education is not fulfilling its responsibilities with regard to section 33 (3ciii) as stated above. In the foreseeable future midwives will retain the responsibility for the provision of antenatal education and preparation for parenthood and so adequate preparation for this role is of paramount importance. The aims of antenatal education should be identified and recognized by all those involved in preparation for parenthood. It has become clear that at present both the theoretical and practical aims of antenatal education require clarification. The origins of antenatal education have been explored and two assumptions were identified in the introduction; (i) that antenatal education

can improve nutrition and hygiene and thus reduce perinatal and infant mortality, and can help reduce pain in labour and (ii) that midwives are the best people to provide that antenatal education. It has not been proven that antenatal education can improve nutrition and hygiene or that reductions in perinatal and infant mortality are attributable to these improvements and if so to what extent. There are many other factors to consider such as improved housing and sanitation, and medical technology which is able to maintain life which previously would have been another mortality statistic which have also influenced mortality rates . This study has found that clients' perceptions of their needs are generally not with reference to hygiene and nutrition but are more related to labour and childbirth and pain relief during labour, but again as to whether antenatal education can improve pain relief during labour is left unanswered. Studies which have attempted to measure this have been conflicting as some have concluded that antenatal education contributes to a reduction in pain whereas others have been unable to find any links.

This dissertation has highlighted the fact that there are many often differing aims of antenatal education. From a theoretical perspective it would seem that implications are that antenatal education should be carried out with a liberating philosophy, in that it should serve to empower women and that this empowerment is more important than the actual content of the classes. What is not addressed is the reason why clients need to be empowered and whether antenatal care generally serves to disempower women. The issue of choice and control have come very much to the fore in midwifery care during the last few years. It is generally assumed that once women and parents have choice they will also have control. In the literature they are often viewed as interchangeable (Skevington and Wilkes 1992) but it may be that they are distinct from each other. It may be too simplistic to assume that if preparation for parenthood education liberates, which again suggests that there is an initial need to liberate as a result of the disempowerment of the care provided, and offers choice to parents they will then be able to take control of the childbirth process. In theory home birth is

available for those who wish it therefore offering choice and control to women as to the place of birth. Realistically there are many other factors which come into play such as attitudes of medical and midwifery staff, information given to women and many other variables, all of which may play a part in reducing the control of the women.

At a micro level the implications for midwives who take part in preparation for parenthood education is that they should teach in a liberal rather than didactic way. This formal style of education is rather outdated both in terms of education generally and in the new philosophy of midwifery care. Education at the present time generally involves such philosophies as student centred learning, self directed study and learning contracts implying a more individualised approach to learning. Midwifery care is also now moving towards individualised care and respecting clients' wishes, so the two complement each other. This is often very different from the methods of teaching the midwives themselves have experienced, especially if the midwives trained some time ago and have not been subjected to the 'learning together' process and as such implies that the midwives themselves need to be educated to educate. This different style of teaching can help to prepare antenatal teachers to use their own experiences to enhance their teaching. At a fundamental level therefore, antenatal education needs to be delivered in a manner which serves to empower women and parents in general and as Ashton (1992) says 'our aim must be to move to a situation where women are not equal partners in their care, but the senior partner' (p 70). Looking at antenatal education specifically, there is a need to ensure that there is raised awareness of clients needs by midwives who can then ensure that they are able to identify and meet those needs, whether it be on an individual or group basis. Gunn et al (1983) suggested that group classes should be replaced by one-to-one sessions integrated into the care clients receive. This suggestion was also highlighted by my own findings that 75% of respondents (including 75% of women who had attended antenatal classes) would prefer to receive antenatal education on a one-to-one basis. Bonovich (1990) found one-to-one teaching far more effective than the more formal group style in reducing the

number of visits to the delivery suite with suspected onset of labour. The answer could be that a variety of different types of antenatal education could be offered, all with their aims explicitly stated. In this way clients would be able to choose for themselves the programme most appropriate to their needs. Clients must also recognise that some individual needs may be met more effectively as an integral part of the care provided rather than in a group setting. Antenatal classes are often seen as a response to consumer demand, and the classes are only as good as the skill of the teacher (Butler 1985). It appears that the role of the midwife with regard to preparation for parenthood has evolved often without clarifying the aims of the education and with the assumption that midwives are best prepared and able to deliver that education. Because of the lack of clear aims which all midwives can work towards, measures of effectiveness have often been different and it is often unclear who the education has been effective for. If the basic purpose and aims are not clear from the outset, it is reasonable to assume that any measure of effectiveness cannot be representative of antenatal education generally. However, it is also important to recognise that people have differing needs. Often even within a small group or area this is so. It is necessary to assess the target audience before planning the curriculum and recognising that the curriculum may be different for different clients. Regular audits are required to ensure that antenatal education is effective in meeting those needs and that clients are satisfied with the service that is provided. With more and more demand being made on resources it is imperative that resources are beneficial and useful. Midwives themselves have identified a need for more education in this role. This should be recognised to ensure that the service delivered is the best possible.

At the outset the aim of this dissertation was to explore on a practical level the role of the midwife with reference to preparation for parenthood. However, it soon became apparent that there are many underlying theoretical and political issues on which preparation for parenthood is based which control the practical issues. It is important

for midwives to understand these issues and work with them in order to provide an effective service for the client.

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Appendix i

Dear Colleague,

I would be very grateful if you would complete this questionnaire. It is part of a study which I am compiling which is looking at antenatal and early parenthood education. Please can you return the completed questionnaire by 5th June 1995. There are collection boxes on each ward, or they can be returned to me on Celyn Ward.

Please circle you answer

Main work area ; Maternity ward Delivery Suite Community

Year midwifery training completed 19_____

1. Do you hold a teaching certificate/qualification? YES NO

2. Have you received training in antenatal and early parenthood teaching ;

(a) As a student midwife ? YES NO
(b) As a qualified midwife? YES NO

3. Do you feel the training you have received in teaching skills has been ;

Not adequate fairly adequate adequate very adequate

4. How important do you feel antenatal and early parenthood education is ?

Not important fairly important *important* very important

5. Please tick six of the following you believe <u>clients</u> most want information about and rank them in order of importance i.e. 1 = most important etc.

order of importance

i. Antenatal investigations_____
ii Diet during pregnancy_____
iii Minor disorders during pregnancy_____
iv Complications during pregnancy_____
v Labour and delivery_____
vi Pain relief during labour_____
vii Relaxation and breathing_____
viii Complications during labour and delivery_____
ix Role of the Midwife and Health Visitor_____
x How to bath baby_____
xi Breast and bottle feeding_____
xii Changes within the family that a new baby brings_____
Any other subjects clients most want information/advice about (please specify)

6. Please tick the six subjects which **you** believe are most important, and rank them in order of importance i.e. 1 = most important etc.

order of importance

i. Antenatal investigations_____
ii. Diet during pregnancy_____
iii. Minor disorders during pregnancy_____
iv. Complications during pregnancy_____
v. Labour and delivery _____
vi. Pain relief during labour_____
vii. Relaxation and breathing _____
viii. Complications during labour and delivery_____
ix. Role of the Midwife and Health Visitor_____
x. How to bath a baby_____
xi. Breast and bottle feeding_____
xii. Changes within the family that a new baby brings_____

Any other subjects you believe a midwife should provide information/advice about to parents (please specify)

7. Which, in your opinion, is the most effective way of providing clients with the information/advice they require?

a. In parentcraft classes b. one to one in clinic/home
c. Other - please specify

8. Should midwives teaching skills be updated ?

annually Every 2 years Every 5 years Never

Many thanks for taking the time to complete this questionnaire. I will be happy to provide feedback at a later date to let you know what the findings of this study are.

Appendix ii

I am Lynne Grundy, a Registered Midwife. I am presenting a dissertation as part of a course I am doing which looks at antenatal and early parenthood education. I am sending this questionnaire to all women who had their baby in the North Clwyd area during the two weeks commencing 29th August 1994. Details of these births were taken from the Birth Register at Glan Clwyd Hospital.

I would appreciate you taking the time to complete and return the questionnaire by using the enclosed SAE by 5th June 1995. Hopefully the information you provide will enable midwives to provide an improved service in the future. All information will remain anonymous. You are under no obligation to return this questionnaire if you do not wish to.

Please circle your answer

1. Was this baby your first? YES NO

2. Did you attend antenatal/parentcraft classes
   (a) During this pregnancy YES NO
   (b) During any previous pregnancy (If this was not your first) YES NO

3. Please tick six of the following which you feel parents most want information about, and rank them in order of importance, i.e. 1 = most important etc.

	order of importance
i. Antenatal investigations	
ii. Diet during pregnancy	
iii. Minor disorders during pregnancy (eg morning sickness etc.)	
iv. Complications during pregnancy (eg high blood pressure)	
v. Labour and delivery	
vi. Pain relief during labour	
vii. Relaxation and breathing	
viii. Complications during labour and delivery (eg Forceps, caesarean section)	
ix. Role of the midwife and Health Visitor	
x. How to bath a baby	
xi. Breast and bottle feeding	
xii. Changes within the family that a new baby brings	

Any other subjects you feel are important :

4. Please indicate which of the following subjects were discussed by your midwife with you and where :

	parentcraft classes	home/clinic
i. Antenatal investigations		
ii. Diet during pregnancy		
iii. Minor disorders during pregnancy		
iv. Complications during pregnancy		
v. Labour and delivery		
vi. Pain relief during labour		
vii. Relaxation and breathing		
viii. Complications during labour and delivery		
ix. The role of the Midwife and Health Visitor		
x. How to bath a baby		
xi. Breast and bottle feeding		
xii. The changes within the family that a new baby brings		

Any other subjects discussed by your midwife -

5. How would you prefer to receive information and advice about pregnancy, childbirth and early parenthood ? (please tick preferred way)

a. At parentcraft classes
b. During clinic / home visits with your midwife
c. Other - please specify

If you would like to check that this research is approved by Glan Clwyd Hospital Maternity Unit, please telephone Mrs Ann Green, Midwifery Manager, Supervisor of Midwives, Glan Clwyd Hospital (0745 583910) Extension 4649 .

Many thanks for your help with this research.

Appendix iii

I am Lynne Grundy, a Registered Midwife. I am presenting a dissertation as part of a course I am doing which looks at antenatal and early parenthood education. I am sending this questionnaire to all women who had their baby in the North Clwyd area during the two weeks commencing 27th February 1995. Details of these births were taken from the Birth Register at Glan Clwyd Hospital.

I would appreciate you taking the time to complete and return the questionnaire by using the enclosed SAE by 5th June 1995. Hopefully the information you provide will enable midwives to provide an improved service in the future. All information will remain anonymous. You are under no obligation to return this questionnaire if you do not wish to.

Please circle your answer

1. Was this baby your first? YES NO

2. Did you attend antenatal/parentcraft classes
   (a) During this pregnancy YES NO
   (b) During any previous pregnancy (If this was not your first) YES NO

3. Please tick six of the following which you feel parents most want information about, and rank them in order of importance, i.e. 1 = most important etc.

	order of importance
i. Antenatal investigations	
ii. Diet during pregnancy	
iii. Minor disorders during pregnancy (eg morning sickness etc.)	
iv. Complications during pregnancy (eg high blood pressure)	
v. Labour and delivery	
vi. Pain relief during labour	
vii. Relaxation and breathing	
viii. Complications during labour and delivery (eg Forceps, caesarean section)	
ix. Role of the midwife and Health Visitor	
x. How to bath a baby	
xi. Breast and bottle feeding	
xii. Changes within the family that a new baby brings	

Any other subjects you feel are important :

4. Please indicate which of the following subjects were discussed by your midwife with you and where ;

parentcraft classes home/clinic

i. Antenatal investigations_____
ii. Diet during pregnancy_____
iii. Minor disorders during pregnancy_____
iv. Complications during pregnancy_____
v. Labour and delivery_____
vi. Pain relief during labour_____
vii. Relaxation and breathing_____
viii. Complications during labour and delivery_____
ix. The role of the Midwife and Health Visitor_____
x. How to bath a baby_____
xi. Breast and bottle feeding_____
xii. The changes within the family that a new baby _____
brings

Any other subjects discussed by your midwife -

5. How would you prefer to receive information and advice about pregnancy, childbirth and early parenthood ? (please tick preferred way)

a. At parentcraft classes
b. During clinic / home visits with your midwife
c. Other - please specify

If you would like to check that this research is approved by Glan Clwyd Hospital Maternity Unit, please telephone Mrs Ann Green, Midwifery Manager, Supervisor of Midwives, Glan Clwyd Hospital (0745 583910) Extension 4649 .

Many thanks for your help with this research.

Appendix iv

GLAN CLWYD
DISTRICT GENERAL HOSPITAL
YSBYTY CYFFREDINOL DOSBARTH

COMMITTEE SERVICES OFFICE

Staff Midwife Lynne Grundy,
Women & Children's Department,
Glan Clwyd DGH

Ein cyf/Our ref: RJM/JW
Eich cyf/Your ref:
Dyddiad/Date June 26, 1995
Wrth ffonio gofynnwch am/If telephoning ask for

Est/Ext. No.

Dear Mrs. Grundy,

Re: Midwives as Educators

Thank you for your recent letter and the revised documentation.

We are happy to give ethical approval for the study to go ahead as we have no ethical objections to the study but we were anxious that you got as much information as you possibly could out of your study.

We would be interested to hear of the progress of your study and will be contacting you in twelve months time in this regard.

Yours sincerely,

YSBYTY GLAN CLWYD HOSPITAL, RHYL, CLWYD LL18 5UJ FFÔN/TEL: (01745) 583910 FFACS/FAX: (01745) 583143
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